DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
MENTAL HEALTH DIVISION
Olympia, Washington

To: All Providers
Managed Care Plans
CSD Regional Administrators
HCS Regional Administrators
CSO Administrators
Regional Support Networks

Memorandum No. 03-16 MAA
Issued: June 30, 2003

For further information, call:
Mental Health Division
(360) 902-0778

From: Tim Brown, Assistant Secretary
Health and Rehabilitative Services Administration

Karl Brimner, Director
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Medical Assistance Administration

Subject: **Psychiatric Indigent Inpatient (PII) Program**

Effective for dates of service on and after July 1, 2003, the Mental Health Division (MHD) will implement the Psychiatric Indigent Inpatient (PII) program.

Why is MHD creating a PII Program?

Effective for dates of service on and after July 1, 2003, the Washington State Legislature discontinued the Medically Indigent (MI) program. MHD created the PII program to ensure eligible clients receive continued voluntary psychiatric inpatient hospital services. The program will continue to fund voluntary community psychiatric inpatient hospital care for indigent clients who qualify under the new program's eligibility rules.

The PII program will be funded with state dollars to provide voluntary inpatient hospital services for clients with an emergent psychiatric condition who do not qualify for other programs. WAC 388-438-0100, which regulates the MI program, will be repealed by emergency order effective June 30, 2003. WAC 388-865-0217 will be effective July 1, 2003, under emergency order and will govern the PII Program.

Refer to **Numbered Memorandum 03-15 MAA** for further information regarding the "Discontinuance of the Medically Indigent Program." View it now at: http://maa.dshs.wa.gov/download/dmn/memos03.html

Who is covered under the PII Program?

This is a new program that will affect indigent clients who receive voluntary inpatient psychiatric care in a community hospital. Individuals must apply for this new program. During the initial months of this program, approved individuals will receive a Medical Assistance Identification Card with the identifier **"MIP-EMER No out of state care"**. By the end of 2003, the Medical ID Card and award letter will change to reflect the new program name. Indigent clients who are involuntarily hospitalized under chapter 71.05 RCW and chapter 71.34 RCW may be covered under other programs. A client will be assigned to the PII program only after it is determined that the client is not eligible for other medical programs.

What is covered under the new PII Program?

The PII program covers voluntary emergent inpatient psychiatric care in community hospitals within the state of Washington. A client is limited to a single three-month period of PII eligibility each 12-month period. These clients are also subject to the $2,000 Emergency Medical Expense Requirement (EMER) during the same 12-month period.

What is not covered under the new PII Program?

The PII program does not cover ancillary charges for physician, transportation, pharmacy or other costs associated with an inpatient psychiatric hospitalization. The PII program covers usual and customary charges for voluntary inpatient psychiatric hospitalization billed on a hospital billing form (UB-92).

Hospitals who usually submit applications for Medical Assistance

Hospitals may continue to submit applications for Medical Assistance hospital care provided to clients who receive community inpatient psychiatric care. Beginning with dates of service on and after July 1, 2003, hospitals must submit the RSN Certification Form (see attachment) containing an authorization number with an application for a client who may be eligible for the PII program. A Community Services Office (CSO) financial worker will review the application and determine eligibility for all possible programs. A client will be assigned to the PII program only after it is determined that the client is not eligible for other medical programs.

CERTIFICATION FORM FOR ADMISSION TO PSYCHIATRIC INPATIENT CARE

_____ REGIONAL SUPPORT NETWORK (AUTHOR. CODE # _____)
CERTIFICATION FOR ADMISSION TO PSYCHIATRIC INPATIENT CARE

NAME:_____ DATE OF BIRTH:_____

PATIENT IDENTIFICATION CODE (PIC):_____

COUNTY OF RESIDENCE:_____

NAME OF HOSPITAL:_____

DATE OF ADMISSION TO PSYCHIATRIC INPATIENT CARE:_____

PERSON GIVING CONSENT TO CARE: ❑Client ❑Parent ❑Legal Guardian ❑Other

LEVEL OF INPATIENT CARE NEEDED: ❑ ACUTE AND EMERGENT

❑ ACUTE AND ELECTIVE

On this date, a screening was completed to assess this client's need for inpatient psychiatric treatment. Based on supporting documentation and/or presentation, we certify that the applicant

❑ DOES or ❑ DOES NOT meet the following criteria:

- Age-appropriate application and/or consent requirements are met
- Ambulatory care resources available in the community do not meet the treatment needs of the client
- Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician
- The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning, AND
- The client has been diagnosed as having an emotional/behavioral disorder as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; **OR**
- The client was evaluated and met the criteria for emergency involuntary detention (RCW 71.05 or 71.34) but care was agreed to.
- In addition, for admission to long term inpatient care, the client has been diagnosed with a severe psychiatric disorder which warrants extended care in the most intensive, restrictive setting.

Signatures of team members certifying need for service:

(1) _____ DATE:_____ TIME:_____

_____TITLE:_____
PRINT OR TYPE NAME

(2) _____ DATE:_____ TIME:_____

_____TITLE:_____
PRINT OR TYPE NAME

INSTRUCTIONS FOR COMPLETING CERTIFICATION FORM FOR ADMISSION TO PSYCHIATRIC INPATIENT CARE

The purpose of the Certification Form is to document the professional's decision regarding the medical necessity for psychiatric inpatient care for an individual. Copies of the completed Certification Form should be kept in the client's hospital record and in the Regional Support Network (RSN)/county management site identified by each RSN. The Certification Form does not have to be provided to Medical Assistance Administration for claims processing. Nevertheless, the Certification Form documents RSN authorization for payment for hospital admission. In order to meet Federal, state and RSN requirements, the following minimal information **must** be included on the Certification Form.

RSN Name and Authorization Code Number: The form must identify the authorizing RSN and the nine-digit code number assigned to each individual claim by the RSN.

Name: Name of client for whom care is being certified

Date of Birth: Self-explanatory

Patient Identification Code (PIC): The code obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as **"JA 011060 JONES A"**.

County of Residence: County where the medical card was issued.

Name of Hospital: Hospital where the admission will occur.

Date of Admission to Psychiatric Inpatient Care: Actual date of admission to the above hospital.

Person Giving Consent to Care: Check one or more of the boxes to indicate the person(s) giving legal authorization for inpatient care. By state law the consent of a minor is not required for admission. Check the **Client** box if the person (age 13 years or older) being hospitalized gives their consent for inpatient care. Check the **Parent** box if the biological or adoptive parent authorizes care for their minor child (age 0-17 years). If the minor also gives consent for care, check both **Client** and **Parent** boxes. If the minor child is over the age of 13 years and does not give consent for care, check only the **Parent** box. Check the **Legal guardian** box if a person who has been assigned guardianship authority gives consent for medical care for the client. The **Other** box allows for additional persons who otherwise have been granted legal authority to consent for care, e.g. parent surrogate, DCFS social worker, Guardian ad litem.

Level of Inpatient Care Needed: Check one box only. Any admission delayed for lack of bed space is not considered to be an emergent admission.

Signatures of Team Members: The required professional(s) must sign and print/type their name and title, and date the form on the same date they sign it.